MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

REQUEST FOR REDUCTION OF CLAIM

TO	Food Stamp Program and Policy Unit		
	P.O. Box 2320		DCN:
	Jefferson City	MO 65102	DATE ESTABLISHED:
RE	HEAD OF CLAIM		ORIGINAL AMOUNT OF CLAIM:

Please complete the following information regarding your financial situation. Include information for all persons who live with you. If they do not owe this claim, their income and expenses will not be counted.

How many people live in your household:	Total cash, bank accounts and CD's:
Does anyone who lives with you receive food stamp benefits?	If yes, who:

Monthly Household Income: (Example: Social Security, SSI, Wages, Unemployment, Child Support, etc.)

Name	Where is Income From:	Monthly Amount of Income

Monthly Expenses: (Example: rent, utilities, car payments, medical expenses child support, min. credit card pmt.)

Type of Expense	Who Pays This Expense	Monthly Amount of Expense

Describe any other reasons that would cause a financial, physical or mental hardship for you to repay this claim. You may use the back of this form for additional comments.:

WORKER	DATE:	SIGNATURE OF PERSON REQUESTING THE CLAIM REDUCED

OFFICE USE ONLY:

Original amount of Claim:	Amount Compromised:	Balance of Claim :
APPROVED BY:	DATE:	CARS-2 SUBMITTED:

CARS-8 (09/04E)